Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Feb 28, 2018;	2017_652625_0005 (A1)	001680-17	Resident Quality Inspection

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

Long-Term Care Home/Foyer de soins de longue durée

Lakehead Manor
135 South Vickers Street THUNDER BAY ON P7E 1J2

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

TIFFANY BOUCHER (543) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

This order has been closed due to the fact that this licensee is no longer responsible for the management of this long-term care home as March 01, 2018. The new licensee will be responsible to ensure compliance with the Long-Term Care Homes Act, 2007, as per the conditions of their licence.

Issued on this 28 day of February 2018 (A1)

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

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TIFFANY BOUCHER (543) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): February 6 to 10 and 13 to 16, 2017.

Additional intakes completed during the Resident Quality Inspection (RQI) included:

- one log related to a Follow-up to Compliance Order #001 issued during inspection #2016_435621_0015 regarding plan of care;

- three logs related to staff to resident abuse;

- one log related to neglect of a resident;

- one log related to a complaint regarding personal support worker qualifications; and

- one log related to a Critical Incident System (CIS) report submitted for an incident that caused an injury to a resident for which the resident was taken to hospital and that resulted in a significant change in the resident's health condition.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director of Care (DOC), the Associate Directors of Care (ADOCs), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), the Resident Assessment Instrument (RAI) Coordinator, Housekeeping Aides, a Recreation Assistant, a Restorative Care

Aide (RCA), the Physiotherapist, Laundry Aides, Dietary Aides, the Food Services Manager, the Resident Services Coordinator, the Recreation Services Manager, the Acting Environmental Services Manager, residents, family members and volunteers.

The Inspectors also reviewed resident health care records, various home's policies and procedures, employee personnel files, the home's investigation files and council meeting minutes. Inspectors conducted observations of residents, observed the provision of care and services to residents, observed resident and staff interactions, home areas, meal services and conducted a tour of resident care areas.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Laundry

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Residents' Council

Skin and Wound Care

Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

4 WN(s)
3 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to comply with Compliance Order #001 issued during inspection report #2016_435621_0015 pursuant to the Long-Term Care Homes Act, s. 6(1)(c) with a compliance date of February 3, 2017.

As part of the order, the home was to:
(a) review and revise the plans of care for four specific residents to ensure that they provided clear directions to staff and others who provided direct care to the residents;

(b) develop a process to ensure that plans of care provided clear directions and were understood by all staff and others who provided direct care to the residents;

(c) develop an auditing process for written plans of care that would identify inaccuracies, so that corrections could be made in order to ensure that the planned care for residents was clearly documented for staff and others who provided direct care to residents; and

(d) educate and retrain staff involved in the development of residents' written plans of care, including the risks associated with not providing clear directions for the

planned care of residents to staff and others who provided direct care to residents.

(A) With respect to part (b) of the order, the home was required to develop a process to ensure that plans of care provided clear directions and were understood by all staff and others who provided direct care to the residents.

Inspector #625 reviewed documents provided by the home titled “Care Plan Review Process” and “Daily Care Plan Reviews”. The documents identified that Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs) and the Resident Assessment Instrument (RAI) Coordinator were to fulfill different roles in reviewing and updating of residents' care plans. The documents did not reference any other components of the plans of care.

The home provided a binder containing RQI entrance information to the Inspectors. The binder contained a sheet of paper that listed the definition and location of the home’s plans of care as care plans and kardexes which could be found on Point Click Care.

During an interview with Inspector #625 regarding the components of the plan of care, ADOC #102 stated that the electronic Medication Administration Records (eMARs), electronic Treatment Administration Records (eTARs) and physician’s orders were also components of the plans of care.

During an interview with Inspector #625 on February 16, 2017, the Director of Care (DOC) stated that they had interpreted the term "plan of care" to refer to the home's "care plans" only and that the process in place for the review of care plans did not include a review of any other plan of care documents, including the eMARs or eTARs, unless the care plan specifically referred to those documents. The DOC also stated that a review of the physician’s orders was not included as part of the care plan review.

The home has failed to comply with part (b) of the order as the home failed to develop a process to ensure that plans of care provided clear directions and were understood by all staff and others who provided direct care to the residents.

(B) With respect to part (c) of the order, the home was required to develop an auditing process for written plans of care that would identify inaccuracies, so that corrections could be made in order to ensure that the planned care for residents was clearly documented for staff and others who provided direct care to residents.

Inspector #625 reviewed documents provided by the home related to the auditing process the home had developed as per part (c) of the order. The audit sheets provided were titled "Wound Care Order Audit" and "Urinary Catheters Audits".

During an interview with Inspector #625 on February 16, 2017, the DOC stated that they had misinterpreted the order and conducted audits on the categories identified in the findings (wounds, catheter use, oral care and sleep preferences). The DOC stated that they had not conducted audits, or developed an auditing process, for the actual written components of the plans of care that could be inaccurate such as physician's orders, eTARs and eMARs.

The home has failed to comply with part (c) of the order as the home did not develop an auditing process for written plans of care that identified inaccuracies, so that corrections could be made in order to ensure that the planned care for residents was clearly documented for staff and others who provided direct care to residents.

(C) With respect to part (d) of the order, the home was required to educate and retrain staff involved in the development of residents' written plans of care, including the risks associated with not providing clear directions for the planned care of residents to staff and others who provide direct care to residents.

A review of the "Education and Training Session Attendance Form" used to capture training attendance for registered nursing staff identified the content as "care plan training". The corresponding "Education and Training Session Attendance Form" used to capture training attendance for PSWs identified the content as "PSW Meeting: Kardex". The content as captured in the "PSW Kardex Meeting" minutes dated January 11, 2017, included references to the kardex and care plans.

During an interview with Inspector #625 regarding the components of the plan of care, ADOC #102 stated that the eMARs, eTARs and physician's orders were components of the plans of care.

During an interview with Inspector #625 on February 16, 2017, the DOC stated that all of the training that had been provided specifically focused on "care plan", not on "plan of care" training.

The home has failed to comply with part (d) of the order as the home failed to

educate and retrain staff involved in the development of residents' written plans of care, including the risks associated with not providing clear directions for the planned care of residents to staff and others who provided direct care to residents. [s. 6. (1) (c)]

2. The licensee has failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

During stage one of the inspection, resident #004 was identified as requiring further inspection regarding a particular skin integrity impairment on a specific part of their body.

Observations of resident #004 were conducted on four different dates in February of 2017, and the resident was observed with an intervention applied on a different specific part of their body.

Inspector #196 conducted an interview with PSW #111 on a particular date in February of 2017. The PSW reported that resident #004 had a previous area of impaired skin and identified that the intervention was applied to that specific part of their body. The PSW stated that the kardex indicated that the intervention was to be applied to a different specific part of the resident's body, but that it was the body part that the intervention was presently applied to that exhibited impaired skin integrity.

During an interview in February of 2017, RPN #113 stated that resident #004 had an area on the specific body part identified in the kardex that was being monitored for impaired skin integrity and that the resident required the intervention applied to that body part to help prevent skin issues.

During an interview with Inspector #196 in February of 2017, ADOC #103 stated that the resident had developed impaired skin integrity on the specific body part listed in the kardex and that an intervention was to be used on that specific body part.

A review of the "Initial Wound Assessment – Treatment Observation Record" dated a specific date in January of 2017, identified that the resident had a specific skin integrity impairment to the body part listed in the kardex.

The current care plan as found online in Point Click Care was reviewed. The care plan identified, under the focus of impaired skin integrity of the specific body part the Inspector had observed the intervention in place on, to apply the intervention to the different body part that was listed in the kardex. Specifically, under the focus of impaired skin integrity, as evidenced by a particular skin integrity impairment of the body part the intervention had been observed applied to, the interventions included application to the other body part listed in the kardex. [s. 6. (1) (c)]

3. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident’s care needs changed.

During stage one of the inspection, resident #001 was identified as requiring further inspection after being observed as being unclean and ungroomed, with specific observations noted of a specific body part.

On a particular date in February of 2017, Inspector #196 observed resident #001's specific body part to exhibit specific characteristics.

On a second particular date in February of 2017, Inspector #196 observed resident #001's specific body part to exhibit specific characteristics.

On a particular date in February of 2017, the Inspector spoke with the resident's family member who commented that they had questioned the staff as to whether the resident had a specific diagnosis associated with the specific body part's characteristics observed.

On a particular date in February of 2017, Inspector #196 conducted an interview with PSW #111 who reported that resident #001's specific body part had exhibited a specific characteristic. The PSW identified that PSWs were to perform a treatment during morning care, at the direction of the RPN. In the presence of the Inspector, PSW #111 reviewed the kardex and found no information regarding the specific body part's characteristics or related care that was to be provided to the resident.

On the same date in February of 2017, Inspector #196 interviewed RPN #112 who reported that resident #001 had a specific diagnosis intermittently for a while, that their specific body part was always exhibiting the specific characteristics observed by the Inspector, and that staff used to perform a particular treatment.

On another particular date in February of 2017, an interview was conducted with RPN # 113 who reported that resident #001 had a specific diagnosis in the past and that staff used to perform a particular treatment at night. The RPN stated that the treatment identified by PSW #111was only performed when ordered by a physician.

The current care plan was reviewed by Inspector #196 and did not reference care to the specific body part or any interventions to direct staff on how to care for the specific body part's characteristics. [s. 6. (10) (b)]

Additional Required Actions:

(A1)The following order(s) have been rescinded:CO# 001

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the rights of resident #008 were fully respected and promoted, including the right to be treated with courtesy and respect and in a way that fully recognized the resident's individuality and respected the resident's dignity.

During stage one of the inspection, resident #008 was identified as requiring further inspection regarding concerns with not being treated with respect and dignity.

During an interview with Inspector #196 on a particular date in February of 2017, resident #008 identified that, in addition to the concerns expressed during the stage one interview, an incident had occurred that date, where the resident had requested an item. The resident stated that, when RPN #110 gave the resident the requested item, the resident was told that they used too much of the item, used the item too often, and that was the cause of the resident's problems. The resident also stated that they felt bad for asking for the item and shouldn't have been given a lecture about it.

An interview was conducted with the DOC who stated that, upon initial investigation into the incident, the resident had stated they felt embarrassed and bad about asking for the item. [s. 3. (1) 1.]

2. The licensee has failed to ensure that the rights of resident #013 were fully respected and promoted, including the right to be properly sheltered, fed, clothed,

groomed and cared for in a manner consistent with his or her needs.

The home submitted a Critical Incident System (CIS) report to the Director for an incident identified as neglect that occurred on a particular date in the winter of 2016/2017. The report indicated that resident #013 asked PSW #105 for assistance with a specific task, and that the PSW responded that it was the end of their shift, they were going home and failed to assist the resident.

A review of the home's investigation file by Inspector #625 included an interview on a particular date in January of 2017, with the DOC, ADOC #102 and resident #013. The interview notes indicated that resident #013 had asked PSW #105 for assistance on a particular date in the winter of 2016/2017, to which the PSW replied that it was a specific time that coincided with the end of their shift and walked out of the room. The notes identified that the resident stated the PSW did not offer to get another staff member to assist the resident.

The investigation file also included notes of an interview conducted by the home on a particular date in January of 2017, with PSW #105. The notes indicated that PSW #105 stated that resident #013 asked the PSW to assist the resident, that the PSW did not assist the resident as it was the end of their shift, that the PSW did not report the resident's request to the next shift, and that the PSW should have assisted the resident with the specific task when asked.

During an interview with Inspector #625 on February 16, 2017, the Executive Director (ED) confirmed that the incident occurred on a particular date in the winter of 2016/2017, as outlined in the CIS report submitted by the home. [s. 3. (1) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following rights of residents are fully respected and promoted:
- the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity; and
- the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (3) The licensee shall ensure that the care plan sets out,
(a) the planned care for the resident; and O. Reg. 79/10, s. 24 (3).
(b) clear directions to staff and others who provide direct care to the resident. O. Reg. 79/10, s. 24 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that, with respect to the 24-hour care plan, the care plan set out the planned care for the resident.

A Critical Incident System (CIS) report was received by the Director related to an incident that occurred on a particular date in the winter of 2016/2017, where resident #018 sustained an injury that resulted in a significant change in the resident's health status. The report indicated that the resident had experienced two other similar incidents during that winter.

On February 16, 2017, Inspector #577 reviewed resident #018's 24-hour admission care plan dated a particular date in the winter of 2016/2017, which was in effect on the date of the incident. The care plan identified that the resident:
- required specific assistance related to transfers;
- used an assistive device for locomotion;
- had been assessed as a falls risk; and
- had specific interventions in place related to falls prevention.

A review of resident #018's health care record included:
- a post-fall assessment dated a specific date in the winter of 2016/2017, which indicated that two new interventions had been initiated; and
- a progress note dated a specific date in the winter of 2016/2017, which indicated that a one of the new interventions had been initiated.

During an interview with the Resident Assessment Instrument (RAI) Coordinator on a particular date in February of 2017, they reported to Inspector #577 that the paper 24-hour admission care plan was the document that all staff referred to for resident information during the first 21 days after admission. They further reported that registered staff were responsible for updating that care plan.

During an interview with Inspector #577 on a particular date in February of 2017, RPN #114 reported that registered staff were responsible for updating the 24-hour admission care plan.

During an interview with Restorative Care Aide (RCA) #115 on a particular date in February of 2017, they reported that on admission, resident #018 was using two specific assistive devices. The resident was given a specific assistive device on a particular date in the winter of 2016/2017 and a specific intervention was initiated on that date. The RCA further reported that the specific intervention was in place the date of the incident on a particular date in the winter of 2016/2017.

A review of the home's policy titled "Assessment and Care Planning - CARE1-010.01" last revised July 31, 2016, indicated that the nurse would develop the resident move-in plan of care or revise the current plan of care, within 24 hours, based on assessment findings and communicate the interventions to the interdisciplinary team.

During an interview on February 16, 2017 with the DOC, they reported that the 24-hour admission care plan was in place until the 21st day after admission and registered staff were responsible for updating the care plan. They further confirmed that resident #018's care plan did not include use of a specific intervention, despite the progress notes which indicated that the intervention had been initiated. [s. 24. (3) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that, with respect to the 24-hour care plan, the care plan sets out the planned care for the resident, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that, as part of the organized program of laundry services under clause 15 (1) (b) of the Act, procedures were developed and implemented to ensure there was a process to report and locate residents' lost clothing and personal items.

During stage one of the inspection, residents #005, #006 and #007 were identified

as requiring further inspection regarding laundry reported as missing which had not been located.

On a particular date in February of 2017, Inspector #196 conducted an interview with PSW #111 regarding missing resident laundry. The PSW reported that residents' clothing was sent to the laundry department for labeling at the time of admission to the home. The PSW stated that if laundry went missing, they would go down to the laundry department and speak to the housekeeper or laundry person, as there was a bin of unlabeled clothing. PSW #111 was not aware of any document to complete if laundry went missing.

During interview with the Acting Environmental Services Manager #116 and Executive Director on a particular date in February of 2017, both stated that there was a "Lost Personal Items Reporting Form" to be filled out and sent to the laundry department when an item of clothing was identified as missing.

On a particular date in February of 2017, during an interview with RPN #117, they reported that staff would go down to the laundry department and look for missing resident laundry items. The RPN stated that they would ask the Housekeeping Aide if they have seen the item and would fill out the "Lost Personal Items Reporting Form".

During an interview with RN #118 on a particular date in February of 2017, they reported that they would mention it to the housekeeping staff and to their manager if needed. The RN was not aware of any paper document that was to be completed when clothing was missing.

On a particular date in February of 2017, Inspector #196 observed two handwritten notes posted in the laundry room. One was written on a paper towel and the second on a blank piece of paper. Each note contained a different resident's name and a description of missing items of clothing.

On a particular date in February of 2017, Inspector #196 interviewed Laundry Aide #119 who reported that, when an item was found without a resident label, it was hung up on a rack in the laundry department, the item was recorded on a tracking form, and staff and family members could come and search to find missing clothing items. In addition, the Laundry Aide reported that unit staff filled out a "Lost Personal Items Reporting Form" and were required to send it to the laundry department when they identified a missing clothing item, resulting in the laundry

staff knowing to look out for the item. The Laundry Aide stated that staff would also write on something like a piece of paper to give to the Laundry Aide so that they knew an item was missing.

On a particular date in February of 2017, an interview was conducted with the DOC regarding the home's process for missing resident laundry. The DOC reported that registered staff were to fill out a "Client Services Response Form (CSR)" and submit to the DOC or ED for follow-up. The DOC stated that “older staff” continued to use the other forms in the home.

Over the course of the inspection, the home’s management team and staff who were interviewed were not able to identify consistent procedures that had been developed and implemented to ensure there was a process to report and locate residents’ lost clothing. The management and staff interviewed reported that a “Lost Personal Items Reporting Form” was to be used, that a “Client Services Response Form (CSR)” was to be used, that any blank piece of paper could be used and/or that no documentation was required. The Inspector also observed that staff had written on a piece of paper towel and a piece of blank paper to report lost clothing items. [s. 89. (1) (a) (iv)]

Issued on this 28 day of February 2018 (A1)

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

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Name of Inspector (ID #) / Nom de l'inspecteur (No) : TIFFANY BOUCHER (543) - (A1)

Inspection No. / No de l'inspection : 2017_652625_0005 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 001680-17 (A1)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Feb 28, 2018;(A1)

Licensee / Titulaire de permis :
Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600, MISSISSAUGA, ON, L4W-0E4

LTC Home / Foyer de SLD :
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135 South Vickers Street, THUNDER BAY, ON, P7E-1J2

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Brittany Dumont

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

To Revera Long Term Care Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

(A1)
The following Order has been rescinded:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007, s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Order(s) of the Inspector

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Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

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Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 28 day of February 2018 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : TIFFANY BOUCHER - (A1)

Ontario

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Service Area Office / Bureau régional de services : Sudbury